**Incident Report**

***REMINDER: All incidents must be reported within 24 hours***

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| Individual Name: | Region: | | | DOB: |
| Date of Incident: | | | Time of incident:       am pm | |
| Location of incident: | | | | |
| Name of agency providing services at the time of incident: | | | | |
|  | |  | | |
| **MEDICAL** | | **LEGAL** | | |
| Hospitalization – medical – admittance not ER visit  Hospitalization – psychiatric – admittance not ER visit  Injury of individual not requiring medical intervention\*  Injury of individual requiring medical intervention\*  Illness of individual not requiring medical intervention\*  Illness of individual requiring medical intervention\*  Seizure  Medication refusal  Fall  Other:  *\*by nursing or medical intervention we mean treatment at a medical facility (e.g. ER, Urgent Care, PCP, etc.)* | | Possible/suspected violation of client rights   *(i.e. potential abuse, neglect, exploitation, or service  rights violation)*  Individual missing/eloped *(even temporarily)*  Police involvement | | |
| **INDIVIDUAL VICTIM OF** | | |
| Theft  Assault  Sexual Assault  Car Accident  Fire hazard/arson | | |
| **SOCIAL** | | | | |
| Behavior incident – no behavior plan  Behavior incident w/behavior plan  Mental Health episode *(suicidal ideation, unusual emotional moods, etc.)*  Physical Restraint utilized  Other: | | | | |

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| **Describe what occurred during this incident (include specific information, i.e. behavior, injury etc.):** |
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| **What happened prior to the incident which may have contributed to its occurrence or to the likelihood of its occurrence:** |
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| **What action did the reporter or others employ in response to this incident:** |
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| --- | --- | --- | --- | --- | --- | --- |
| **Who was notified (Include name, date/time and method of contact):** | | | | | | |
| **Name** | **Relationship  to individual** | **Date** | | **Time** | | **Method of contact** |
|  | Service Coordinator |  | | am pm | |  |
|  | Program Supervisor |  | | am pm | |  |
|  | Guardian |  | | am pm | |  |
|  | Additional Service Provider (ex: home) |  | | am pm | |  |
|  | Nursing (if applicable) |  | | am pm | |  |
| Other: |  |  | | am pm | |  |
| Printed Name: | | | Title | | | |
| Signature of Reporter | | | Date | | Time | |

**REVIEWS**

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| **Program Manager Review/Follow-up** | | |
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| Has the individual had a service transition within the past 6 months (new home, new home care provider, significant change in service delivery)?  Yes  No  If yes, describe the transition and its relationship (if any) to the incident that occurred above: | | |
| Did incident result in nursing or medical intervention? Yes No If, yes, please attach Nursing/Medical Intervention Report. | | |
| If it is a behavioral incident with plan, was the behavior plan followed?        Yes  No | | |
| Signature of Program Manager | Date | Time |
| Printed Name of Program Manager | Title | |

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| --- | --- | --- |
| **Service Coordinator/Case Manager Review/Follow-up** | | |
|  | | |
| Is a team meeting required at this time? Yes No | | |
| Signature of Service Coordinator/Case Manager | Date | Time |
| Printed Name of Service Coordinator/Case Manager | Title | |